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Introduction

In this paper some tendencies in health system policy that appear to be converging across European health systems are discussed. Based on the first section, which introduces some concepts and approaches related to comparative health system analysis, several examples are explored in the second section: choice, capitation, contracting (taken as a group), and rationing of health care. The discussion deals with the paradox of convergence and divergence in the dynamics of health systems and suggests that issues of governance are taking front stage as the dilemmas and contradictions resulting from an exclusive focus on specific technical tools of health policy become clear.

I. Conceptualizing comparative health system analysis

Anyone involved in cross country comparisons of health systems is likely to have had the experience of speaking directly to someone from another country and discovering that his previous understanding of the other country's health system was flawed. Even when the same words are being used to describe a phenomenon, for example a tool of health policy such as "reimbursement by DRG (diagnosis related group)" the content validity may differ between the home country of the analyst and the system he has chosen for comparison (1). When Germans discuss adopting "Australian DRGs" (2), the problem of referring to something which is both the same and yet different is posed.

Even without going into Platonic distinctions between the world as we perceive it and the ideal world (3), this characteristic of international comparative health system research has been taken up by others. Field (4) discusses how health systems are simultaneously converging in terms of key structural parameters while at the same time retaining rich differences.

Brown (5) identified ten major common health policy themes in a collection of articles about a number of health systems:

- Coverage;
- Funding;

- Costs;
- Providers;
- Integration;
- Markets;
- Analysis;
- Supply;
- Satisfaction;
- Leadership.

However, closer inspection might reveal that, for example, the issue of leadership in one country is tightly coupled to provider payment schemes, while in another these two elements are quite loosely coupled.

Twaddle (6) proposed four theoretical ideas as a framework for understanding the evolution of health reform in Western countries:

- Professional patient relationship;
- Modalities for the organization of health care;
- Internationalization of economies;
- The role of economic elites.

Again, it is reasonable to assume at one and the same time that each of these features will be identifiable in most health systems, but the clarity of the distinction among them might differ across countries.

Saltman (7) drew attention to policy instruments under consideration in European health systems, identifying three dimensions: finance, allocation and production *(Table 1)*

While this array is quite useful in bringing together prominent policy moves taken in many countries, it must be supplemented with sensitivity to differences in the meaning of the terms. For example, negotiated contracts may be quite "hard" in one country, implying ready resort to legal recourse, while in other countries contracts may be so "soft" as to imply not much more than a clear articulation of the expectations of two parties to a transaction (8). Indeed, Saltman himself (9) points to the importance of "social embeddedness" in understanding health system reform.

For the purposes of this review of current dynamics in European health systems, it is proposed to keep in mind the general systems approach to comparative analysis of health systems offered by Ellencweig (10). His "modular" approach exhorts those engaged in comparative health system research to be sensitive to the overall context in which specific system elements exist. *Figure 1* displays this approach graphically.

Table 1

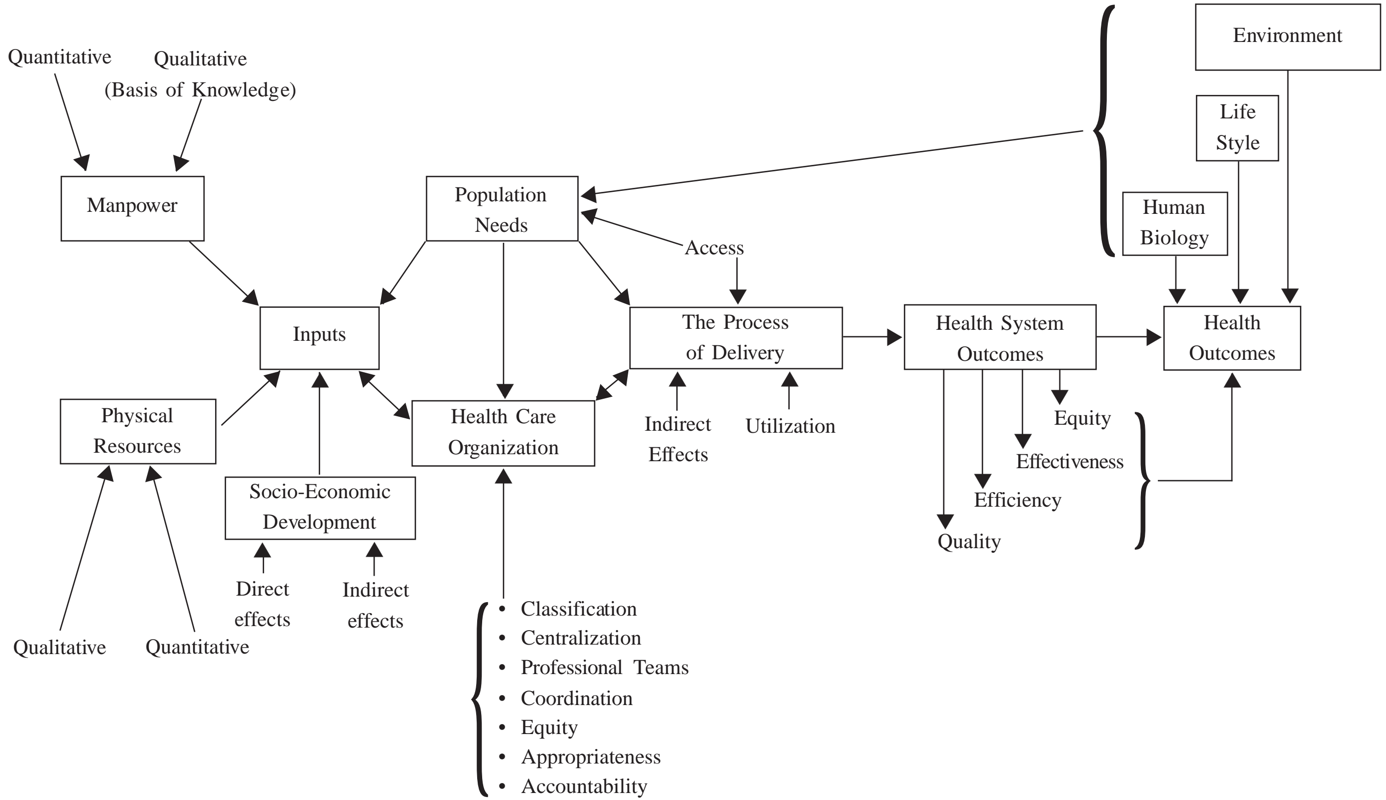
FINANCE	ALLOCATION	PRODUCTION
Competitive mechanisms between private insurers	Negotiated contracts	Quasi-autonomous management of public hospitals
	Patient choice	Competitive mechanisms between hospitals and physicians
Increased private insurance	Giving hospital budgets to primary care providers	Decentralizing service delivery
	Mixture of capitation with other GP payment arrangements	GP as gatekeeper
Increased social insurance	Reference pricing for pharmaceuticals	Privatizing service providers
	Positive lists for pharmaceuticals	Improved coordination between health social services, especially for elderly
	Copayments and deductibles	Quality improvement
	Cross cutting initiatives	
	Improved information systems	
	Enhanced preventive services	
	Patient rights	

Source: (7)

This portrait, or, as Ellenxweig called it, "modular approach" captures the overall richness and complexity of health systems, while at the same time sharpening the focus on individual components. Attention of policy analysts and decision makers, given the nature of human cognition and, in particular, what Herbert Simon labeled "bounded rationality" (11), will always be drawn to one component. The modular approach reminds us, however, that any change in one component will be limited by and affect numerous other modules. This is one reason why what one sees from a distance when looking at one aspect of another health system will look quite different to someone more familiar with the entire system.

This approach is complex enough when looking at comparative "static" positions of health systems. Of course health systems, like all systems, are in constant flux, and recently appear to be the subject of major change. As this dynamism only adds to complexity, the modular approach aids in simultaneous attention to one or a few modules, while keeping the big picture in mind. For example, while Saltman's finance, allocation, and production schema, above, lays out a complex and rich variety of policy tools, the modular approach reminds us that these tools represent specific components within a much vaster system. Note that the finance, allocation and production schema fits into two modules in the center of the model, organization and

Figure 1 — A macro model of a health system



delivery, but does not deal directly with inputs, such as manpower, or with outcomes, such as health status. Similarly, when Brown discusses providers, the emphasis is on reimbursement, fitting Ellencweig's organization module, but not on other issues having to do with supply or educational curricula of the health workforce. Turning to outcomes, it is perhaps not surprising that Brown focuses on satisfaction, an outcome most readily linked to issues of health service organization and delivery of care. Other outcome measures, such as overall health status of populations, have received less attention in the literature on health care reform. Indeed, public health academics and practitioners have long decried the large amount of attention given to reform of *health care,* in their view to the pushing aside of more important issues of population health, prevention and the determinants of health.

These examples highlight another advantage of the modular approach. While attention may be focused on organization and delivery of health care, the links to other modules are seen and analysts may also keep track of linked developments in other modules. The emphasis on organization and delivery has led to impacts on other modules such as the health workforce. New allocations of responsibility between professions, such as the medicine and nursing are encouraged by changes in finance, allocation and production. At the same time, though, existing parameters of the workforce also constrain changes sought in the process of health care, such as decentralization and separation between purchasers and providers and the conversion of hospitals to public firms. Other environmental factors, such as increased migration of the health workforce and of patients, for example in the context of regulations of the European Union, force health policy analysts to take a new look at health workforce issues and integrate them into policy tools aimed at finance and delivery of health care. On the outcome side, contracting for health care, as will be discussed below, has contributed to clearer definition of service baskets to be provided by health care systems and to prioritization of health care services. Such priority setting confronts extremely difficult challenges within the *health care* system, but perhaps public health issues such as the determinants of health can garner more attention due to the precedent of priority setting being set regarding health care.

While the notion that components of health systems are interrelated may be obvious, its importance cannot be overstated and is often overlooked. The learning of lessons from abroad in health policy is rife with discussion of technical tools removed from their larger organizational and social contexts. The modular approach encourages tracking the evolution of changes that are rippling throughout the system, offering the opportunity to seize policy opportunities that might be otherwise overlooked.

A final conceptual perspective is helpful in operationalizing this systems approach, namely, a focus on policy implementation. Following Bardach (12), implementation should be seen as a series of games played by the stakeholders concerned with a given policy. From the modular approach we glean that the array of players may be very large. The skill of the policy analyst is in being able to identify which games are, or could be, played by which actors and how this could affect the outcomes of policy interventions. In effect, Bardach's concept of implementation games offers a way of managing and governing the complexity of health systems.

In the following section we apply these conceptual perspectives to a number of policy directions notable in the rhetoric, literature and data emerging over the past few years in European health systems. Following from the above, we seek to identify the policy trends, view them in the context of the modular approach and consider the complicated interactions, or games, that ensue as the policies are enacted and acted out.

II. Policy tools and contexts

In this section we will turn our attention to some policy instruments that have been receiving a great deal of attention in a number of countries. European health systems have been grappling with setting the balance in the relative roles of governments and markets in health systems (13). As part of the global trend towards "New Public Management" health policy makers in many countries have sought to reduce direct involvement of central government in the management of health systems, or, as some have put it, let governments steer more than row. This is part of what has been described as the main objectives of health systems reforms, namely, "efficiency and client satisfaction in health care together with solidarity and the effective control of aggregate spending." (14).

Regarding the last point, control of spending, over the last decade European health systems have been struggling to contain total health expenditures. The ratio of growth in GDP per capita to growth in health expenditure per capita has been about three to two over the last decade. Health expenditure as percent of GDP has risen by about one point on average for a selection of European countries (three points for Portugal!) over the last decade (16). However, this is a perfect example of the contextual approach outlined above. It is difficult to know whether health expenditure might not have risen even more without some of the policy interventions discussed below. Moreover, some countries started with a much lower baseline of spending and

perhaps need to "catch up", especially in view of demographic such as aging or absorption of immigrants or, in the case of Germany, integration of two previously separate health systems.

The focus on cost containment has manifested itself in moves aimed at both macro efficiency and micro efficiency (7). At the macro level, governments have sought to cap national health budgets, through the politics and techniques of national budgeting and through controls on prices and rates of health premiums or contribution rates (17, 18). However, it is politically untenable to simply "clamp down" on expenditure by edict from above without searching for new efficiency measures lower down in the system. Thus, enter the type of policy interventions to be discussed below. Ironically, in some cases moves aimed at micro efficiency, whether or not they actually succeed in their technical intended aims, provide the political system with the underpinnings to actually *increase* aggregate expenditure (19).

In the remainder of this section we will focus on such efficiency moves initiated regarding specific health system elements at the micro level. What we shall see is that it is not possible to confine policy to single elements, and that outcomes at the micro level have implications for outcomes at the macro level.

a. Choice, capitation and contracts

The word "choice" has become a buzzword of health policy reform in many European countries. It is currently the center- piece of health policy in the United Kingdom. Choice is like motherhood and apple-pie: it is hard to find fault with a policy that seeks to extend more choice to citizens.

Of course, the desire for choice is very subjective. The work of prominent economists such as Herbert Simon (11) and Tversky and Kaheneman (19) casts doubt on the assumption implicit in the approach of many economists that more options are always better and that individuals always prefer to choose for themselves. Indeed, in many cases the citizen prefers that some other agent choose, and then the problem takes the form of ensuring that the agent chooses what is best for the citizen and not according to some other, perhaps self-serving, interests.

Beyond the simple, and, as just mentioned, possibly questionable assertion that patient or citizen choice is a desirable aim, the first question health policy makers have to address is "choice of what?" Citizens might be given the right to choose their individual physicians, the hospital, the insurance provider or health plan, or even the mode of treatment. Each of these mean-

ings of choice has different implications for allocation of responsibility for health system outcomes.

For example, in the UK health reforms of the early 1990s, citizens were given the right to choose general practitioners (GPs), but GPs and health district authorities shared the right to choose the hospital on behalf of the patient (20). In the Swedish reforms of the same era, patients could (depending in which county they lived) choose both the primary care group and the hospital. Since then, in part as a way of dealing with long hospital queues, the UK politicians have been pushing patient choice of hospital, while patient choice of physician has been quietly suppressed (21). In Sweden, on the other hand, patient choice has been enshrined in law, while in part in response to the outcomes of patient choice, hospital districts have begun to coordinate services in order to enable county led planning to cope with patient movements (22).

In the Netherlands and Germany, on the other hand, citizen choice was focused on selection among competing sick funds. Both countries "floated" the idea of sick funds choosing providers for their insured through the mechanism known as "selective contracting; ie, choosing to work with only certain providers (23, 24). In neither country has selective contracting really taken hold. Citizen choice in reality seems much more focused on selection of physician and/or hospital than on selection of sick fund, and sick funds contract with most physicians and hospitals in a given geographical area.

Israel provides a good illustration of how citizen or patient choice, while noble in principle, becomes vague in practice. Israel's National Health Insurance Law (NHI) mandates the following provisions regarding choice: citizens have free choice of sickness fund; citizens are given the right to choose from among those providers with whom the sickness fund contracts; some services may be regionalized by government. In practice, the main focus of choice is on citizens' choice of physician and hospital (25).

How are we to understand these policies regarding choice and their evolution in different countries? One clue is to think about other system components and they interact with the choice dimension. It turns out on closer inspection that it is impossible to separate choice from the question of how providers are paid. While systems may appear to be similar in promoting choice, the particular form this take in each country is related to reimbursement mechanisms.

One of the most prominent forms of reimbursement on the agenda of a number of countries is "capitation." Under capitation, providers or insurers receive a fixed sum of money for each person served or covered. Hospitals

may be capitated for a group of patients, sickness funds may receive a per capita sum each person enrolled, and physicians may be capitated for each person on their patient list. The idea of capitation is to control costs by providing a fixed sum of money in advance. It is also used to increase equity in health systems, by ensuring that providers are fairly rewarded.

Making sure that the capitation payments are "fair" has become a central focus in the literature on European system changes. A number of countries have used capitated payment to competing health insurers as their chosen mode of allocation of health care resources. If the capitation payment is perceived as not adequately covering risks, however, insurers are expected to avoid risky clients by engaging in risk selection or "cream skimming." Much has been written about different methods of adjusting capitation payments to take into account the actual risks associated with insuring individuals (14). The literature indicates that commonly available adjusters, such as age and sex, are not adequate to the task of preventing cream skimming; too much risk is left unexplained by these parameters. What is interesting is that while this appears to be a technical problem to which there should be an answer applicable to all health systems, different countries have come up with different proposed "adjusters" for their capitation formulae. In the Netherlands they are thinking about adding "pharmacy- based cost groups (PCG) while in Germany they are looking at Disease Management Programs (DMP) (23, 24). Is this due to cultural differences, the types of data available, or proclivities in the style of medical care? Finally, it is also interesting that in European countries, capitated insurers have shown only anecdotal signs of engaging in cream skimming (14, 23), so the necessity of refining the capitation formula is, in part, socially and ethically determined.

Even if there were no problem of cream skimming, a capitated system might give insurers an incentive to under-serve in order to save money. If a patient chooses a given health insurer or general practitioner, the latter will receive the capitation payment determined for that citizen. If a patient chooses a certain hospital, the latter will receive the payment that goes with that patient. In other words; "money follows the patient." But if money follows the patient in this fashion, a mechanism must exist to ensure that the citizen or patient receives adequate health care in exchange for having "had the money follow him or her" to the provider. Enter contracts. For example the organization (health insurer, health region, general practitioner etc) holding the budget on behalf of the patient may negotiate a contract with the provider regarding the nature of the service to be provided, in terms of both cost and quality. In the next section we take up recent developments regard-

ing the substantive content of contractual agreements. At this point what is important to point is that the legal context and the status of contracts varies across cultures. Is the contract truly a legally binding document actionable in court? What are the sanctions for violation of contractual agreements? Is the contract a real legal agreement, or more a framework for increasing the clarity of mutual goals and objectives, i.e. more like a professional understanding or "gentleman's agreement?" It appears that in most European contexts, contracts are softer rather than harder, especially if compared to the US context (8).

b. Rationing

Deployment of policy tools such as the combination of choice, capitation and contract become interrelated with rationing of health care and quality assurance. The need to contract summons forth the need to explicitly detail what is to be provided. Thus, many European countries appear to be converging on trying to meet the challenge of explicit health care rationing (26). At the same time, governments have felt increased need to monitor and improve the quality of health care. The recent Institute of Medicine Report, "Crossing the Quality Chasm," (27) documented the extent of medical mistakes and mishaps in the US, finding that medical errors are one of the leading causes of mortality in the United States. Scandals over breakdowns in the quality of care have plagued the UK National Health Service (NHS), and in other countries, such as Israel, newspapers are often filled with stories of medical mishaps.

Thus, we see the rise in a number of health systems of institutional mechanisms for making resource allocation, including coverage decisions, as well as for monitoring the quality of care. But the blend of these mechanisms varies across countries. For example, as part of Labor Party led health reforms in the late 1990s, the UK created national level bodies charged with overseeing resource allocation and quality. One, the National Institute for Clinical Excellence (NICE), is charged with exploring medical treatments, technologies and pharmaceuticals, and, based on various approaches to assessment, issuing guidelines as to what services will be covered throughout the NHS (28).

In Germany, as part of recent reforms (not coincidentally linked to the *contract* regarding the coverage of drugs by sickness funds) an Institute for Quality and Efficiency was created, to perform a similar task to that of NICE

(17). But, unlike NICE, the German Institute is financed jointly by the sickness funds, physicians, and hospitals, reflecting the "coorporatist" type arrangements characteristic of German health care. One implication might be that the authority of such a body is derived from centralized control and legal status in the UK, while it is nested in the cooperative nature of the German system.

Another difference not immediately identifiable by simple noting of the fact that such similar institutions have arisen in different countries is the degree of financial accountability of such bodies for their own decisions. In the UK, NICE issues clinical guidelines that appear to be quite binding, but it does not allocate the budgets, say, for its decisions to include new drugs in the offerings of the NHS (18, 28). In Israel, in contrast, a special committee decides on additions to the basket of services that the sickness funds must provide, but subject to a budget constraint imposed by the Ministry of Finance and the Budget Law (29).

Implicit in these differences among various countries are differences in attitudes towards accountability. In the UK, the tendency has been to try to focus accountability for rationing decisions at the level of groups of general practitioners. However, general practitioners respond to the decisions of NICE by pointing out that without additional budgets, anything mandated by NICE will have to come at the expense of services previously provided by the NHS, which traditionally have included all "necessary" medical care. Thus, accountability is thrust back to the national level. This pattern is seen in health resource allocation decisions in a number of countries (30). As countries converge in the need to ration health care more explicitly, they diverge in defining the locus of responsibility for such tough decisions. Indeed, the picture is made even more complex by the entrance of another actor with a complex mix of incentives regarding taking on accountability for health rationing decisions: the European Union. For example, new requirements in the Netherlands that private health insurance carriers provide a standard package of services set by government, appears to run afoul of mandates of the European Union (31). This becomes part of the environment of each national health system, and, undoubtedly, each will interact with that environment in a different, reproducing the convergence-uniqueness conundrum.

III. Discussion

The examples discussed above of current directions in European Health Policy illustrate that what appears to be the same phenomenon conceals, or

at least diverts attention from important differences of context. These differences derive from culture, existing institutional structures, and the interplay of stakeholders.

Moreover, the overriding focus of health reform activity on process oriented tools related to finance, allocation and production of health care services has limited the amount of attention given to inputs such as workforce and outcomes such as health status. The modular perspective, however, helps to locate the impacts of changes in the process of health care that might induce corresponding changes in inputs and outcomes. There appears to be a return to issues of the health workforce as a major input and renewed interest in indicators of health status and the determinants of health, possibly linked to priority setting in health care.

The lessons offered by the modular approach and the for health policy analysts and decision makers are clear: 1. when focusing on any one element of the health system for intervention, pay attention to the linkages to other elements, or at least be aware of them as an aid to improved management of implementation; 2. when looking at policies implemented abroad, consider the hidden contextual factors that may make the meaning of the policy quite different across different countries.

When combined with a view of policy implementation as a series of games, a final lesson is that health policy change is never limited to technical interventions, no matter how well refined (e.g. the attempt to continually fine-tune capitation formulae). The management of the health system requires simultaneous attention to the evolving inter-relations among a large number of stakeholders (representing, in part, different health system modules) and thus considerable political skill. Thus recent health reforms in European countries, especially when combined with the evolving role of the European Union, have highlighted the importance of governance and stewardship in health systems. Improved governance may itself contribute to health outcomes, as much literature indicates that social capital, which includes trust in social networks and public institutions, contributes to population health. Thus, *health care* policy, as it evolves, becomes linked to health policy more generally conceived.

Thus, we end where we started: arguing that all health systems are converging in the need for artful governance, but knowing full well that such governance will differ greatly across systems.

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